MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, December 13, 2001
10:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
What next for Medicare + Choice?
Scott Harrison

DR. REISCHAUER: We're going to get started on what's next for Medicare+Choice. Scott?

DR. HARRISON: Now that you've taken care of fee-for-service, we'll deal with Medicare+Choice.

Today we will present our continuing refinement of the Medicare+Choice chapter for the March report. I think this slide sums up the mood surrounding the Medicare+Choice program. Plans continue to profess displeasure and leave the program. Beneficiaries are unhappy with the plan exits and the plan benefit reductions. And the Congress is unhappy with the situation and continues to grapple with geographic inequities where some parts of the country have no plans at all. And last, but not least, we at the Commission, along with the economists are unhappy because the payment system is causing market distortions between the Medicare+Choice plans and the traditional Medicare fee-for-service program in local market areas.

MedPAC has recommended that we move to a financially neutral payment system, meaning that the expected Medicare contribution should be equal between Medicare+Choice enrollees and those remaining in traditional Medicare. This would at least solve the last problem and may help plans remain in payment areas where the payment rates are below risk adjusted fee-for-service spending.

In order to attain a financially neutral payment system we need to do more than just set the rates at 100 percent of traditional Medicare spending. Last month we detailed the need to push forward with the development of an adequate risk adjustment system and we have no news on that front for this month.

Last month we also discussed the graduate medical education payments paid to teaching hospitals that are currently carved out of the calculations of the Medicare+Choice payment rates. In just a minute, I'll turn it over to Ariel to discuss a draft recommendation on that.

Other adjustments we could mention in the chapter include the use of counties as the definition of the payment areas, which last year we recommended the Secretary examine. In the past, we've also been concerned about how the interaction between the Medicare, Veterans and Department of Defense programs should be treated in rate calculations. Unfortunately, staff have not examined those questions recently and we are unprepared to offer any draft recommendations at this time.

Finally, last month the issue of the limits on beneficiary cost sharing in plans was mentioned as interfering with the plan benefit design. Staff has begun to look into the issue but in our brief examination we've discovered it's quite tricky and we're not ready to share anything with you yet.

Now I'll turn it over to Ariel to discuss a potential recommendation on the GME carve-out.

MR. WINTER: First I'll quickly review how the carve-out works, which I discussed in more detail last month. Under the carve-out, direct graduate medical education and indirect medical education payments to teaching hospitals are removed from M+C payment rates and paid directly to teaching hospitals when they serve M+C enrollees. This was done based on the assumption that plans use teaching hospitals less and pay them less than fee-for-service.

I will explain how this carve-out appears to be inconsistent with the principle of financial neutrality between M+C payments and fee-for-service spending.

The Commission has said that GME and IME are really payments for patient care provided by teaching hospitals, not for graduate medical education, except for the portion of IME payments that exceeds estimated additional costs in teaching hospitals which you discussed earlier. Because GME and IME represent spending on patient care they should be treated like other fee-for-service spending on patient care when determining M+C rates. Thus, GME and IME payments should be included in those rates in a financially neutral payment system.

Based on this reasoning we have developed two options for a recommendation for you to consider. The first option reads, Congress should include direct and indirect medical education payments to teaching hospitals in M+C payment rates. The second option is the same as the first option but adds a sentence at the end that reads, however, payments in excess of estimated additional costs in teaching hospitals should not be included.

I'll now open up the floor to your discussion and comments.

DR. ROWE: Can we have an estimate the relative amounts or the relative size of the amount? It's half of the IME, right?

MR. WINTER: Right, the empirical cost -- the IME payment is an adjustment of about 6.5 percent right now to payments, and the empirical level is, I believe, about 3.2 percent. The 6.5 will actually decline to 5.5 percent in 2003.

DR. ROWE: Is the DME included? You're including DME as well here, right?

MR. WINTER: DME we've included in both of those options.

DR. ROWE: How much is DME?

MR. WINTER: Total payments, I'm not sure.

DR. HARRISON: I know that one way to phrase this is that the total that we're talking about is about 5 percent of total Medicare spending.

DR. ROWE: And the part we're talking about in option two --

DR. HARRISON: It might be closer to four, four to five.

DR. ROWE: -- is about how much of that five? Two maybe?

MR. WINTER: 1.3.

DR. ROWE: I'm just trying to understand what's the functional difference between one and two. How much is it?

DR. HARRISON: Option one would probably be 4 to 5 percent.

DR. ROWE: And option two?

DR. HARRISON: Option two then would be probably around 3 percent.

MR. HACKBARTH: So it's a couple of billion dollars.

DR. HARRISON: Yes.

MR. MULLER: But as we know from page 12, the distribution of it is -- so let me -- I just want to make sure I understand our policy last spring which is the teaching hospital adjustment was a reconsideration of what the purpose of that, but it was not -- it was still meant to be a teaching hospital adjustment in the same magnitude as before. You did not decide to reduce it, right? So whether one calls it a GME, IME discussion as it is in current law or one calls it a teaching hospital adjustment per the report, it's still the same magnitude.

So the logic, therefore, of having a teaching hospital or a GME adjustment, the purpose of it is still to be given for those -- is still intended for those purposes, and therefore should be given to the teaching hospitals, correct?

MR. WINTER: Actually, the Commission has said that GME spending and the portion of IME spending that is directly related to additional cost in teaching hospital should be viewed as spending on patient care.

MR. MULLER: In teaching hospitals

MR. WINTER: Right; exactly.

MR. MULLER: So it's intended to -- whether it's called teaching hospital adjustment, DME, IME, it's intended in the fee-for-service program to be funneled to teaching hospitals.

MR. WINTER: That's right.

MR. MULLER: In this carve-out, whether one calls it teaching hospital adjustment, or under current law the GME, IME, is a payment intended to go to teaching hospitals. So by saying it should now be spread across other places you're changing the logic of the Commission, aren't you? It was not the logic of the Commission to spread that money to other hospitals, was it?

DR. ROWE: We're not saying spread to other hospitals. Is that you're recommendation?

MR. MULLER: I'm just reading what you say here.

DR. NEWHOUSE: I actually disagree with the final conclusion of the staff here so let me say -- I mean, I think it doesn't follow that thus the GME and IME should be included in the AAPCC. So let me say what I think the issue is here.

First, given the carve-out, the teaching hospital leaves money on the table unless it lowers its rates to attract M+C customers -- lowers its rates to the M+C plan.

DR. ROWE: I don't understand.

MR. HACKBARTH: Because it only gets the money if it has the patients.

DR. NEWHOUSE: Because it only gets the money if -- otherwise it goes back to Treasury. On the other hand, if the money is not carved out and goes to the M+C plan, then the M+C -- then the teaching hospital doesn't lower its price, the M+C plan has more money with which to afford that price. The same amount of money is in the system either way.

So the real issue I think here is what kind of incentives should the plan face when making a choice between using teaching and non-teaching hospitals. So in one case they face a higher price for teaching hospitals, they'll shift, presumably, some patients toward non-teaching hospitals. There may be some patients that get shifted inappropriately. On the other hand, if they face the same price there may be some patients that could just as well be cared for in the community hospital who are in teaching hospitals.

So there's two types of errors. The issue is our judgment in how we balance out those errors.

Let me make one other analogy and say, in the amount -- CMS has put some restrictions through regs on the degree of risk that can be funneled down toward physicians. They can't accept more than a certain amount of risk. That's an effort to alter incentives down at the physician level. If the carve-out could be seen as a way of altering incentives at the plan level in a kind of similar way -- that is, you either do or do not want to have the plan face a cost difference, with the money to pay for it if it chooses to pay for it, when making the choice between teaching and non-teaching hospital.

Actually I personally come out on the side of the carve-out given that analysis, but I think reasonable people could differ depending on how you think, where you think the balance of patients should be between teaching and non-teaching hospitals.

MR. HACKBARTH: So, Joe, you're saying that if the patterns

of care stay the same, the financial result will be a wash?

DR. NEWHOUSE: Yes, on average. Obviously any individual hospital --

MR. HACKBARTH: Right, on average. So the public policy question before us is --

DR. NEWHOUSE: If it doesn't remain a wash, then teaching hospitals have in effect given money back to the Treasury, which I assume they'll figure out that they don't want to do that.

MR. HACKBARTH: Right. So the policy question before us is not whether to give money to HMOs or teaching hospitals, but whether we should err on the side of maximizing latitude for HMOs in terms of appropriate hospital use and patterns of care, or whether there ought to be a public policy in favor of use of teaching hospitals.

DR. NEWHOUSE: Yes, how much -- who should make the call and under what incentives.

MR. MULLER: Let me also say, there's evidence in the prior meetings and literature and so forth that the HMOs don't direct all the care. There's a lot -- Jack and others spoke last month about how physicians in these open networks, even in HMOs, direct a lot of care, make choices. So it's not necessarily the HMO, per se, some central office directing the care. The physicians make the choice. So they may not act the way Joe's rational people might act in terms of not wanting to move the people to the teaching hospitals.

But I'm trying to deal with just what we're saying here in this document and make sure I understand it, which is the purpose of the carve-out was in fact to isolate this money and say it would go directly to the hospitals. Now I'm saying by the way I read your document here is that you're suggesting otherwise and that you want to blend it back in. So you're basically suggesting a change from Commission policy.

MR. WINTER: Not from Commission policy, no. We're trying to make it consistent with the Commission's policy of financial neutrality. We're saying that the plans should have the discretion to decide how to spend that money that's being spent by Medicare on fee-for-service beneficiaries.

MR. MULLER: Maybe one last -- but the teaching hospital adjustment in the fee-for-service was intended to go to the teaching hospitals, right?

DR. ROWE: Can I ask --

DR. ROSS: Jack, can I do a clarifying thing just before you do because I think it will help a couple of points here, one of which is the set-up for this. This is a recommendation that follows on the heels, assuming the Commission still feels this

way, of financial neutrality for Medicare between beneficiaries in fee-for-service and in Medicare+Choice.

First of all, in the current world, in this world of blends and floors this doesn't, as we've seen last month, make a whole lot of sense, but for quite different reasons. Jack, to your point on what's the magnitude. On the very short run there is no magnitude because of the floors and the blends. This is looking farther ahead.

The second point, I think the gist of the issue is not that it's reversing Commission policy. Joe disagrees with staff and I guess I'm still staff, so I think it does get to what Glenn brought up of the difference in treatment patterns between the two settings, and which one one wants to favor. I don't think it's a question of the views of what Medicare should be doing with its explicit payments for patient care on the fee-for-service side. The question you face is, do you want to leave plans on the M+C side free to make whatever treatment decisions they make, be it teaching hospitals, other hospitals, or non-hospital care? That's the issue.

DR. ROWE: I think I'd like to at least give my understanding of what this is and see if I can get it corrected because I think I disagree on one point with respect to what Ralph said. I think the original intent was to give this money directly to the teaching hospitals because we didn't believe that the plans would pass it on to the teaching hospitals. And we wanted to give it to them because we thought that the money was paying for teaching. It was intended to go to the teaching hospitals to pay for teaching.

Then somewhere between then and now we discovered, in some epiphanous moment that Dr. Newhouse had, that in fact the money wasn't paying for teaching. It was paying for patient care. That is the important point that I think maybe Ralph didn't emphasize. So that, yes, we intended it to go when we thought it was for teaching. But now that we've discovered that it's really for patient care, we think that it should go with the other money for patient care that goes into the local market negotiation and the prices.

Do I understand where we are?

MR. WINTER: Yes, that's a good summary of the recommendation, of the point behind it.

DR. STOWERS: This is difficult to explain, but off of what Jack is saying. I think when a hospital fills out its cost report for GME reimbursement or funding it's based on the number of Medicare patients that they take care of. This money was originally money that was put within the Medicare+Choice

payments. I don't understand why we're making it so complex except for this patient care thing of, just leave this money in the general GME pool and pay the hospitals where they are based on the number of Medicare patients that they take care, and that would be your incentive.

This idea of saying that one county is getting more money or particular Medicare money, how we -- there's two things I don't understand. One is, the first is what Jack said. The second thing is how we start worrying about how the GME funding should go within a particular county or not when it was general GME funding in the first place. So I'm having trouble making the leap to the plans distributing money that was not their money in the first place to distribute.

DR. ROWE: I think Joe's point, or the staff's point is it was their money to distribute in the first place and we didn't realize it.

DR. ROSS: Scott, correct me if I'm wrong, actually under TEFRA when we were at 95 percent of AAPCC there was no carve-out. Those GME costs and IME costs were in a capitated --

DR. STOWERS: They were, but maybe they shouldn't have been and that's why the carve-out is there.

MS. NEWPORT: That's the point. Historically, carving out the GME was based on the old AAPCC. Simultaneous with that we rebased the payments for the plans. We delinked it from fee-for-service. So there's still fee-for-service demand, if you will, for the money but the plans aren't -- and this is the point that we have to keep coming back to, remind ourselves that the plans are not -- on 2 percent counties in particular where most of the teaching hospitals are, that the anomaly here is that you're really restacking the boxes in terms of where the GME payments are going or not going.

So we have, by basing a change on the old AAPCC methodology and not basing it on how we're being paid now, I think that's where the staff gets to on this budget neutrality piece, or payment neutrality. Sorry, I'd better be careful with that. But I really think that the staff recommendation is in alignment with how we're paid now and not -- the genesis for the GME carve-out was based on the old AAPCC payment problems.

The conclusion here too, some problems with some of the statements in terms of where the incentives are for plans to contract with teaching hospitals. We contract in teaching hospitals in areas where there are teaching hospitals. Where there are no teaching hospitals, guess what? So in those negotiations there are administrators satisfied or not satisfied with the payment rates and therefore they contract with us or

don't contract with us.

So I think we just need to be careful here in aligning our understanding of the historical path that we've gone down with the consequences that have resulted here in terms of 2 percent update is a 2 percent update.

MR. FEEZOR: I guess I'm unencumbered either by an epiphany or the board's previous position since I was not here last spring and fall. So forgive me for this. But what I will tell you from trying to deal with managed care organizations, at least in the commercial market, that I've not been as successful in dealing with this most recent round of cost. Coming from the hospital side is going to be, I think, a new round of products that are going to very significantly and very severely tier the provider, and particularly the provider institutions.

The early indications with some of my vendor partners are that in fact teaching hospitals will be circled and there will be increased pressure on that. So my guess is that we'll see some of that same pressure within the Medicare+Choice be manifested very soon. I just wonder if in fact, it might be cumbersome, but if in fact the carve-out was still maintained but then ultimately was floated, even after the fact, back through the managed care organizations.

In other words, in Janet's case, that the organization is trying to cut its best deal with a teaching hospital, goes ahead and contracts for it, but then there is, at the end of the year there's an adjustment for how many +Choice patients she took, and in fact there is an additional add-on that flows directly, keeps the monies unique. Now that may --

DR. ROWE: A rebate.

MR. FEEZOR: Yes, to some degree.

DR. REISCHAUER: That's what happens now.

MR. FEEZOR: Is that the way it works now?

DR. REISCHAUER: When Janet goes in she says --

MR. FEEZOR: Somebody is figuring out that there's an extra --

DR. REISCHAUER: -- we'll put this much on the table. But remember, CMS is going to pay an extra $65.

MR. FEEZOR: -- she's got an extra 3 percent or whatever.

MS. NEWPORT: Some hospitals say, so what.

DR. ROWE: Most of them.

MR. FEEZOR: So it still doesn't make enough to commit.

DR. ROWE: The hospitals say, no, that's for our teaching.

DR. REISCHAUER: But it's exactly what they get for a fee-for-service patient. So if they say, so what, you can --

MS. NEWPORT: We have some hospitals that are asking for 130

percent of fee-for-service.

DR. NEWHOUSE: Assuming the hospital is going to charge its costs, which may be a heroic assumption but that seems like a good starting point, if you give the money to the plan, the plan only gets to keep the dollars if it moves patients out of the teaching hospital. Otherwise it's going to pay the higher cost of the teaching hospitals and the monies will go back to the teaching hospitals. So again I come back to the point, the issue is what incentives does one want to have the plan facing, or the doctors in the plan facing, or the doctors the plan has in its network when it's making choices about where to put patients.

DR. ROWE: Let me ask you a question, Joe. If we were starting all over again and we hadn't had GME or an epiphany or anything else, and Medicare was going to pay money that was all patient care costs, and there were going to be teaching hospitals, non-teaching, rural hospitals, urban hospitals, whatever, would your recommendation be that some of these patient care costs get paid directly by Medicare to one group of hospitals and not to another group of hospitals, and get carved out of the payment to the plans? Or would your recommendation be that all the patient care monies get paid to the plans so they can negotiate with the different hospitals?

That's where we are now. If we forget the history, that's the question on the table. What would your recommendation be?

DR. NEWHOUSE: As I said, I would have actually gone with the carve-out because I'm more worried about the error for inappropriately taking patients out of teaching hospitals than the error of inappropriately having too many patients there. But other people could differ. They could say there's a lot of patients in teaching hospitals that don't need to be there and that if we give managed care the choice to manage this they'll save money in appropriate ways by moving people out of teaching hospitals.

DR. ROSS: Joe, I don't want to take a position on this, but if you had folded GME into the base payment rates you wouldn't know what the carve-out was anyway.

DR. NEWHOUSE: You could figure it out. You could always figure out what the higher cost of teaching hospitals was.

DR. ROSS: No. But this is not just about IME. This is about GME and the subsidy as well.

DR. NEWHOUSE: But it's about the higher cost of teaching hospitals.

DR. ROSS: But GME isn't one of the higher costs of teaching hospitals.

DR. NEWHOUSE: The issue is how to deal with the higher cost

of teaching hospitals, how to measure that with --

DR. ROSS: That's an IME concept, not a GME concept.

DR. REISCHAUER: In a funny way, plans should be anxious to have this carved out because the amount that is taken out is based on the average for the fee-for-service sector. Janet could put all of her patients in teaching hospitals, assuming they like that, and the hospital would get paid for all of these. If they had the money themselves because it wasn't carved out they wouldn't have that option. So you have no upside risk at all with a carve-out. Take it to the advertisers, Janet.

[Laughter.]

MS. NEWPORT: Yes, I will. I'm having a little epiphany here. Excuse me just for a second.

Going back to what Ralph said earlier on a different topic about if we were smart enough to allocate things perfectly we'd still have 100 percent. We have percent of premium contracts with all of our Medicare providers except for very rare instances. The reason is the revenue is what the revenue is coming in by member. So de facto, there's no really -- the extra money goes through on the percent of premium contracts, if you will.

MR. MULLER: But it's 6 percent in New York and 100 percent in --

MS. NEWPORT: In the marketplace when 100 percent of the hospitals are teaching hospitals, that goes to Bob's point, perhaps.

MR. MULLER: But most of the country isn't like that.

MS. NEWPORT: Most of the country is not like that. But I think that the issue is that inasmuch as the payment differential carve-out has affected the ability of counties to have a blend or not have a blend, which in most instances has happened, this doesn't put any real extra money on the table. So the reallocation and our incentives is very different in the size markets that we're participating in. In some markets hospitals, teaching hospitals have come to us and asked for 130 percent of Medicare fee-for-service payments in order to contract with them.

So the economics are much different, and the negotiations are much different in a perfect world. So in rebalancing the scale, if you will, in looking at this, if we're going to go back, as we have advocated, to a payment that is 100 percent of what fee-for-service with appropriate adjustments, which I think we've recommended in the past, then it seems to me that it's parallel to take a look at this in terms of what really does happen with the money on the GME piece of this.

If it is to go to care, I think we need to understand what

has happened here, which was a surprising result for the staff I know in terms of where the money actually ended up going. From some plans that had no teaching hospitals at all to other areas where the teaching hospitals were, that that wasn't the money necessarily from the plans that were in that market.

DR. ROWE: I would say I think that the idealized economic analysis, which is maybe the right analysis, does not reflect at least our experience, in that it is much more local market based. I think that if you're in Baltimore and you're negotiating with Johns Hopkins and you're a health plan, they're not saying, we're going to take 5 percent less because we know it's going to come in from Medicare directly. It's hard to sell a health plan in Baltimore if we can go to all the firms in Baltimore and say, sign up with us and you can go to any place you want in Baltimore except, of course, Johns Hopkins medical institution.

It just doesn't play out the way you guys would like to think it plays out.

DR. NEWHOUSE: But my scenario assumes competition.

DR. ROWE: It's just not there, I don't think. Maybe it is in some places, but in most places it isn't.

MR. HACKBARTH: Could we do a straw vote here on option one? I'd just like to see where we stand. Unlike the previous discussion around payment adequacy, this really isn't data driven. We may as well get to the bottom line on this as quickly as possible.

So option one is on the table. All in favor of option one?

MR. SMITH: But isn't the real choice, based on this discussion, doesn't it need to include an option three, which is no change?

DR. NEWHOUSE: So you just vote no.

MR. HACKBARTH: Yes, you just vote no. So option one is saying, let's change current law to put it back in the M+C rates.

DR. ROWE: Totally.

MR. HACKBARTH: All in favor of doing that raise your hand. So nobody is in favor. That makes it easy.

MS. NEWPORT: Are you going to do option two?

MR. HACKBARTH: Okay, option two. All in favor of option two?

It's relatively easy.

[Laughter.]

MR. SMITH: Let's try option three.

MR. HACKBARTH: Which is just leave it alone. I have a guess on the outcome of that. All in favor of option three, which is just leave it alone, raise your hand.

Did I miss you on one of these, Carol?

MS. RAPHAEL: No, I'm still cogitating.

MR. HACKBARTH: So you're abstaining so far.

DR. NEWHOUSE: This is only a straw vote.

MR. HACKBARTH: We are in a position of dealing with a recommendation to change current law that has the support of only a couple commissioners. So what's going through my head is, how do we handle that in our report?

DR. ROWE: Is this a required report?

MR. HACKBARTH: No, we're not required to say anything on this.

DR. ROWE: So there's your answer.

MR. MULLER: There's your answer.

DR. HARRISON: This would just change the shape of the current draft of the chapter, that's all.

MR. HACKBARTH: And you are the only one who cares about that.

DR. ROSS: It will shorten it, for example.

DR. REISCHAUER: You have to convince yourself that the principles of MedPAC are reflected in current policy on this issue here.

MR. FEEZOR: Glenn, if I might, to pick up on Janet. I had some of the actual writing, the narrative of the chapter, there were some assumptions that I think seemed to be appropriate from a theoretical standpoint but aren't borne out, at least in the market that I'm familiar with, about where we basically are subsidizing floor counties and that therefore there are a lot of plans that are rushing in there is the implication. We haven't seen that. But I'll take that up in a sidebar conversation with staff.

DR. REISCHAUER: I think there's a couple of phrases in there where you used the word subsidy to plans as if there were plans that were laughing all the way to the bank, as opposed to you're creating an unequal playing field.

MS. NEWPORT: So now that we've taken care of this carve-out are going to look at the rest of the chapter, or is that --

DR. HARRISON: That's what I'm here for.

MS. NEWPORT: I felt that we accomplished so much, so I wanted to stop while we were ahead.

DR. NELSON: I wanted to understand what Allen meant when he indicated that the private sectors plans in areas with academic institutions were circling. I didn't understand exactly what --

MR. FEEZOR: Just the early indication from when we've asked some of our vendor partners to look at some tiered products to reduce the price of our HMOs and our commercial non-Medicare, but Medicare tends to follow that shortly. Clearly in the tiering in

the first run of institutions they would or would not include -- academic institutions were noticeably absent in most of the scenarios that have been worked up for us. Am just concerned about that.

DR. NEWHOUSE: Boston is starting to see differential copays on teaching hospitals.

DR. ROWE: In Massachusetts, the Blue Cross plan -- Blue Cross, I believe, payer in the market -- have gone to their members and said, if you want to go to the teaching hospitals you'll have to pay a copay, which you won't have to if you go to these other hospitals. If there is a perceived difference in quality, which I believe there is, then -- and there may be a real difference in quality. I also believe in that. Then some of the members will be willing to pay that, and some won't. But we're not one of those plans, but that's --

MR. MULLER: Engaging in these predictions I think is a different -- I mean, it's like, reminds me of the old Bolshevik general at the time of the revolution who was asked, what's going to happen? He says, the future is clear, but the past is murky.

[Laughter.]

MR. MULLER: I think these kind of forecast of what's going to happen we can all engage in. I think it's hard not to -- sometimes to figure out exactly -- I just note the kind of debate that was going on here a few minutes ago as to what really drives referral and choice and so forth. I think there's a lot of differential evidence in different parts of the country as to what happens. I think a lot of people still think that physicians drive choice rather than plans and so forth, and I think all of you conceded that in the discussion last month.

So on the one hand, we might want to go into hypotheticals as to what -- how the world is going to change 180 degrees with these new plans. But my sense is a lot of traditional patterns will continue to do that.

MR. HACKBARTH: Okay, let's proceed with the rest of the presentation.

DR. HARRISON: Now that we have succeeded in resolving these other little pesky adjustment issues and we're ready to implement a financial neutral payment system, beneficiaries and the Congress still have some other goals for the Medicare+Choice program that will not be addressed.

One issue with the Medicare+Choice program that would remain under a financial neutral payment policy is that beneficiaries living in some parts of the country would have access to Medicare+Choice plans with extra benefits, and beneficiaries in other parts of the country would have no choice aside from the

traditional Medicare fee-for-service program. Many beneficiaries and members of Congress view this as inequitable.

Others, however, might not see any problems with the geographic, or so-called intermarket equity, because they see equity in that everyone in the country can join the traditional program for the same Part B premium.

The financial neutral payment policy would not change intermarket equity considerations, although there would be financial equity between beneficiaries enrolling in Medicare+Choice plans and those enrolling in traditional Medicare within each payment area; what we call intramarket equity. The variation in Medicare fee-for-service spending precludes solving both issues simultaneously, and the Commission has chosen to focus on the intramarket equity because market distortions could arise or continue to arise if they're not solved, and the proper measure of intramarket equity is not really clear-cut.

Other problems. At least in the short run it is unlikely that moving to financially neutral payment rates would result in a significant increase in choice for beneficiaries, especially in areas where no choices currently exist. It's possible that in high cost areas where updates have been constrained rates could increase, and thus encourage plan entry. But most high cost areas have plan choices right now.

Under a financially neutral payment system, low cost areas are likely to see lower payment rates and these areas could lose some of the choices that they have.

Finally, the financially neutral policy MedPAC recommended would not lower Medicare program costs. It wasn't designed to. Under the financial neutrality principle, in setting the payment rates for Medicare+Choice plans at the level of fee-for-service spending it shouldn't result in significant program cost changes.

If we want to address the other goals some have suggested that we look at competitive bidding. Proponents suggest that adding a competitive bidding process to a financially neutral payment system would be more equitable across the country, encourage greater plan participation, and reduce Medicare costs. Last month we discussed that the Medicare program already features competitive bidding, but the bids do not affect Medicare's contribution in the form of payment to plans.

Although there are many possible competitive bidding models, we are focused on models that would be compatible with a financially neutral payment system. Compatibility requires Medicare contribution to be equal for beneficiaries that enroll in the Medicare+Choice plans and beneficiaries that remain in the traditional program in the local area. Also, the benefit

packages on which the plans bids are based would need to be the same in traditional Medicare and in the Medicare+Choice plans.

As a result of these considerations, we will look in more detail at a model that would determine the government contribution based on the bids of the plans and the local Medicare fee-for-service costs. If the government contribution resulting from the bidding process did not apply to beneficiaries in the traditional Medicare program the financial neutrality principle would be violated.

For simplicity in choosing a model with which to illustrate some of the basic issues, I'm assuming that the government contribution is equal to the lowest bid in the local area. It doesn't have to be but it seems to be an easy illustration.

The traditional Medicare program's bid would be its expected per capita spending in the area. As shown on the chart there, there would be two different market types. One with only the traditional Medicare program and one with traditional Medicare and at least one private alternative in the market. In markets with only traditional Medicare there would be no difference under the competitive bidding system and the current one; Medicare pays for fee-for-service care and the beneficiary pays the Part B premium.

In markets where there is another bidder, the government contribution is set at the lowest bid. If a beneficiary remains in traditional Medicare, the program pays the fee-for-service costs as before but the beneficiary pays the usual Part B premium plus the difference between the expected fee-for-service costs in the area and the government contribution.

If a beneficiary enrolls in a plan, Medicare pays its contribution to the plan. The enrollee would pay the Part B premium plus an additional premium equal to the difference between the plan's bid and the government contribution. But of course, if the beneficiary enrolled in the lowest cost plan the bid would be equal to the contribution so there would be no additional premium.

Before I go on to examine what might happen under such a system, are there any questions about how the payment mechanism, this illustration would work?

DR. NEWHOUSE: That's just an illustration?

DR. HARRISON: Just an illustration.

So what would happen under this competitive bidding model and would address any of these other goals that financial neutrality would not address on its own.

Before I talk about the geographic equity I need to note that the very nature of the Medicare entitlement would change

here. Beneficiaries would no longer be entitled to receive the traditional Medicare fee-for-service program for a set premium. Instead beneficiaries would be entitled to receive the standard benefit package that is offered under traditional Medicare but would not be guaranteed that those benefits would be delivered through the broad choice of providers that are available in the fee-for-service program.

As for equity, this competitive bidding model offers a different sense of geographic equity than the current model. All beneficiaries nationwide would have access to the basic benefit package at the same Part B premium and all would have to pay if they wanted a more costly plan, unlike the current situation where all beneficiaries nationwide have access to the traditional Medicare program at the same Part B premium and beneficiaries in some areas have access to plans with extra benefits for no additional premium.

Choice. Would payment rates based on competitive bidding encourage more plan entry? In areas where there are not currently any plans, it's hard to come up with any reasons why a plan that was not already participating would decide to participate under these competitive bidding rules that could only lower payments compared to financial neutrality. In areas where there are alternatives to the traditional Medicare program, the fact that beneficiaries would have to pay more to remain in traditional Medicare could create more opportunity for other plans to compete for those beneficiaries.

However, authors of a recent study published by Health Affairs have concluded that competitive bidding is unlikely to result in significantly greater enrollment in Medicare+Choice plans. The authors, Ken Thorpe and Adam Atherly of Emory University were kind enough to run a special microsimulation comparison of our financial neutrality recommendation with this illustrative model. They found that the plan enrollment would be virtually unchanged.

Finally, cost growth under this type of system would depend on the results of the annual bidding process, but total spending in any local area would be limited to the level of per capita spending under the traditional program.

In the Health Affairs article, Thorpe and Atherly estimated that a model similar to our illustrative model would generate savings to the Medicare program of close to 10 percent of total Medicare spending. These savings would be produced from additional payments paid by beneficiaries remaining in fee-for-service, and some of those savings would come from lower payments to Medicare+Choice plans.

Assuming that the use of competitive bidding to set the government contribution would result in lower government contributions, and that the beneficiaries in some areas would be required to pay higher premiums to remain in the traditional program, two types of trade-offs would pop up. One type is a trade-off between higher premiums paid by beneficiaries and cost savings. Those cost savings could be distributed either to taxpayers or to all Medicare beneficiaries through lower Part B premiums, or through an improvement in the standard benefit package.

The other type of trade-off would be at the geographic level. Areas of the country that had plans providing extra benefits at minimal cost would probably not have access to such good bargains after competitive bidding was implemented, and would have extra premiums imposed on their residents who choose to remain in traditional Medicare, while areas of the countries without plans would either be unaffected or would benefit if overall savings are used to lower Part B premiums or to enhance the basic benefit package.

That's what I think the illustration would do.

MR. HACKBARTH: What is assumed about the distribution of risk? For example, in Thorpe's analysis he says that there's going to be a 10 percent savings. Is he just assuming that there's normal distribution of risk across plans? A fear that I would have is that in fact the highest risk patients would stay in traditional fee-for-service Medicare, driving up the premium of that plan, and so the out-of-pocket premiums that people would have to pay to stay in Medicare fee-for-service could get quite high.

DR. HARRISON: My guess is that what the simulations were based on was past bids that had been submitted. I believe in one of the competitive bidding demos, and I think looking at old ACRs, I would imagine that both of those still had selection in them so probably some of that bid difference would be due to selection.

DR. REISCHAUER: This doesn't assume perfect risk adjustment?

DR. HARRISON: I think it assumes it, but I don't think that the numbers that were in it actually could have supported that because I don't think they could have risk adjusted them.

MR. HACKBARTH: Let's set aside how they did their analysis. Again, my guess is that in the real world there would be not a normal distribution of risk across plans. All the evidence that we have suggests that there would not be a normal distribution risk. So there would be upward pressure on the Medicare fee-for-

service premium as a result of the selection process. Potentially you could get into a spiral where it goes up and up and up and the healthier people keep running out the door and it goes up faster and faster and faster.

DR. HARRISON: I'm not sure that's any different than what we have now because -- especially when 2003 rolls around, we are going to have competitive bidding, but the only difference is where the contribution is set. So you're still going to have relative differences between fee-for-service and plans that could lead to a spiral. I mean, you could have the same problem.

MR. HACKBARTH: But under the 2003 rules there's a limited rebate that they're allowed to give up to --

DR. HARRISON: That's true, up to the Part B premium.

MR. HACKBARTH: So it's a constrained system.

DR. HARRISON: That's right.

MR. HACKBARTH: Whereas if they're actually paying a premium for Medicare that's unconstrained upward, it could just soar upward.

DR. REISCHAUER: I don't think it's -- the dollar value is constrained, but then they can add on benefits. So in effect it's not unconstrained.

DR. ROWE: Let me see if I understand what happens in the current floor counties, because there were floor payments put in in a lot of rural counties particularly to try to keep M+C plans there. As I understand this is going to have a very significant adverse effect on the rural M+C program where it does still exist. Am I right in understanding that there would be no floor counties, there would be no floor payments? Congress has raised these payments up above the Medicare expenditures.

So that what would happen is the payment to the M+C plan would fall to -- if there were no other bidders but one M+C plan, which is often the case in rural areas -- that it would fall to the current Medicare payments. That would wipe out all the floor county effect; is that right?

DR. HARRISON: Even in our baseline, so to speak, we assume that there are no floors because in financial neutrality there would be no floors.

DR. ROSS: That's what we recommended last --

DR. REISCHAUER: That was our recommendation. You voted for it.

DR. ROWE: No, I'm not against it or for it. I'm just trying to make sure I understand it because so much of our discussion here is about geographical shifts, and what's good for this and what's good for that. I just want to make sure it's clear to everybody what this isn't good for, which is the floor

counties.

MR. HACKBARTH: So this is the next step beyond that neutrality.

DR. NEWHOUSE: I think this is obvious, but just to put it on the table, one can have competitive bidding and then there's still degrees of freedom about both where to set the contribution and how or how much to geographically adjust. So one could set the government contribution at the level of traditional Medicare and say there's rebates or some percentage of the difference rebates to people that choose a cheaper plan. That might exacerbate Glenn's fear about a premium spiral in traditional Medicare.

DR. HARRISON: That is -- our financial neutrality would do exactly that.

DR. NEWHOUSE: I thought I heard you say you were setting the government contribution at the level of the lowest bid.

DR. HARRISON: Right. The difference in adding competitive bidding was to potentially change setting it from the 100 percent of fee-for-service. Our financial neutrality recommendation would set things at 100 percent of fee-for-service.

DR. NEWHOUSE: They're financially neutral. Because you're just giving a lump sum it's financially neutral either way.

DR. HARRISON: That's right.

DR. NEWHOUSE: The only issue is the magnitude of the lump sum.

DR. HARRISON: Exactly.

DR. NEWHOUSE: That's my point. You can have competitive bidding with a lump sum at any level. And my reading at least of the political tea leaves is that the only way you're likely to get competitive bidding is to set it at the level of traditional Medicare. But that's another debate.

A second degree of freedom is the degree of geographical adjustment in the lump sum. We can adjust it
-- implicit in this is that it is at the county level. But obviously you can dial that up or down toward a national average and still have a lump sum, with presumably people in places like Minneapolis then either getting rebates or more benefits, and people in the Miamis of the world paying more, if you go toward a national average, or not, as one does.

But I don't know where the Commission is headed in this in the way of recommendations. But if we're headed toward a competitive bidding kind of framework then I think we need to lay out that there's clearly several options within a competitive bidding framework. There's not just one option.

DR. ROSS: If you'll pardon the pun, I just wanted to review

the bidding on this a little bit and go back to Scott's opening slides which are, why are we doing this at all? The answer is that where the Commission was last year in terms of this principle of financial neutrality gets you some of what you want, but in terms of larger concerns we have about M+C and the geographic issues it doesn't do it for you. So the notion was, is there another mechanism out there, a magic bullet that possibly gets you some of these? At least the take from these slides and this illustrative option is, it doesn't look like it.

MS. NEWPORT: I would concur with that. I think there's been a lot of discussion, political discussion around competitive bidding, FEHBP program is the magic silver bullet for the M+C program. I think it was part of the request to the staff was we should look at this. And some of this defaults to those huge transitional issues that revolve around any kind of change, much less going from a local, whatever process you call it now, to a transition to some kind of competitive bidding piece, including what's bid where and how you set the payment. There's a lot of political issues around that.

But just being able to lay out some of the, perhaps challenges, it goes back a little bit to earlier discussions to with year after year after year of nothing but change, change, change. It's hard to then fail to understand at that point why there's such lack of interest in continuing to participate in the program. But I think some of the discussion is valuable.

Whether we put it in the chapter at this point or not may be an open question, but I think it is a debate that we would have been engaged in right now to a greater extent than we have been. But we're sure looking forward to something like that next year or the next two years on this. So how we inform Congress on this -- maybe we need to relook at how we approach this, but I think we need to throw up at least some straw men on competitive bidding in order to be able to answer some of those questions.

MR. SMITH: Scott, let me see if I understand where you ended up. I thought I did and I thought it was right. Let me try to frame it in terms of which beneficiaries are likely to be better off if we go down this path.

It seemed to me that what you concluded is none. That in floor counties beneficiaries would be no more likely to have access to additional benefits or lower costs than they are today. In more competitive markets beneficiaries might be able to get the same level of service but with their choice constrained, or be charged an additional premium. In which case it sounds to me as if the answer is, in those situations no beneficiary is better off.

We've reduced the ability of a plan to say in a market like New York, in this marketplace we can give you a drug benefit, we can give you additional preventive work, because they would be constrained by the lowest price for traditional Medicare. So in cases where Medicare+Choice is working we would eliminate its ability to work. And in places where it is not working we would not improve them. Is that stated maybe a little more bluntly than you did, but did I get it right?

DR. HARRISON: Yes. The only way people would end up, anybody would end up better off is if the savings were taken from premiums paid in New York and spread across the country in the form of either higher benefits or premium --

DR. NEWHOUSE: But I think that depends on where you set the contribution. If I set the contribution --

MR. SMITH: Remember, I said beneficiaries, not tax --

DR. NEWHOUSE: I'm taking that. So if I set the contribution high enough -- take Minneapolis. I set a traditional Medicare contribution, presumably people that switch to a +Choice plan and take a rebate, think they're better off. Now Minneapolis is unusual, I'll grant you, in many ways. But if you set it at the lowest bid, then almost by definition no beneficiary is going to be better off. He'll be worse off.

MR. SMITH: But don't you have to, in that circumstance, Joe, set it at the lowest bid for the traditional plan? Why on earth would --

DR. NEWHOUSE: For the traditional -- that's not a bid on the traditional plan.

MR. SMITH: Sure it is.

DR. NEWHOUSE: That's just what the cost is.

MR. SMITH: Sure it is. That's the way it would be structured. So in Minneapolis Carol bids 87 percent of the current fee-for-service costs, but in order to do that she has to eliminate the drug benefit and the preventive services that she had previously included in her M+Choice plan in that competitive marketplace. Somebody is going to underbid fee-for-service costs, and that becomes not simply the floor; it becomes the ceiling.

MR. HACKBARTH: I think we may be finished on this subject.

DR. HARRISON: For next month, I assume the draft chapter would end on a note of, this doesn't look like a promising way to go and we would reiterate that we want to head toward financial neutrality.

DR. ROWE: Could you send us a copy of Thorpe's paper?

DR. HARRISON: Yes.

DR. ROWE: That would be great. I think it's convenient

that that happens to have been done now.

DR. ROSS: We can even just send you the link.

DR. ROWE: Or you could just send us the reference and we can find it ourselves, if it's too much --

DR. HARRISON: It's the new technology --

DR. ROWE: If it's too much of a burden for you to send us the paper. Just send us the reference.

DR. HARRISON: They didn't actually print it. This is a web paper.

DR. REISCHAUER: It's the web version of Health Affairs.

MR. HACKBARTH: So if you just go to the Health Affairs web site it's one of the first articles there.

DR. ROSS: In return for supplying the toner and the paper you get it a couple days faster.

MR. HACKBARTH: Is that it on Medicare+Choice?

So our last item for today -- and we are now 10 minutes ahead of schedule -- could I have your attention in the audience, please?